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Governor

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Lieutenant Governor

State of Utah

Utah Department of Health

Scott D. Williams, M.D., M.P.H.
Executive Director

A. Richard Melton, Dr.P.H.
Deputy Director

Allen Korhonen
Deputy Director

Iona M. Thraen, ACSW
Division Director
Health Systems Improvement

Date: June 28, 2004

To: Current State Primary Care Grants Program Grantees

From: Don Beckwith, Public Health Program Manager
Office of Primary Care and Rural Health

Subject: State Primary Care Grants Program Process for State Fiscal Year 2004-2005

The Office of Primary Care and Rural Health, Utah Department of Health, invites all current State Primary Care Grants Program Grantees to submit an application for continuation of their funding through State Fiscal Year (SFY) 2004-2005. Please be aware that the Utah Department of Health continues to maintain the policy that agencies awarded under the State Primary Care Grants Program will provide primary care services for the full duration of the Grant Period, and ensure that continuity of services is maintained for that Grant.

The application and self-evaluation must be completed and submitted to our Office by **Friday, July 30, 2004**. The information may be submitted:

- by fax (801) 538-6387,
- by email to Don Beckwith at dbeckwith@utah.gov, or
- by mail to P.O. Box 142005, Salt Lake City, Utah 84114-2005.

Note that Applications submitted after the deadline may be delayed or denied review.

Please pay particular attention to the quality of your narrative, and assure that your Application is clear, succinct, and answers all of the points listed in the Application. If you have any questions about preparing the narrative, please feel free to contact me at (801) 538-6818.

Current State Primary Care Grants Program Grantee's may apply for up to the same amount of funding as received in their State Fiscal Year (SFY) 2003-2004 grant. You will be *expected* to provide no less than the same number of users and encounters as in your SFY 2003-2004 grant. You will be paid the same cost per encounter as stated in your SFY 2003-2004 grant. If you project fewer users/encounters, *you will be paid for those users/encounters at the SFY 2003-2004 rate*.

Please be aware that the State Primary Care Grants Program is a competitive program and an Application to the Program does not guarantee continuation, or future funding.

Attachments

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2004-2005 Application Instructions

A COMPLETE APPLICATION must be submitted by **Friday, July 30, 2004**, to the Office of Primary Care and Rural Health. The Application may be submitted:

- by fax (801) 538-6387,
- by email to Don Beckwith at dbeckwith@utah.gov, or
- by mail to P.O. Box 142005, Salt Lake City, Utah 84114-2005.

Applications that are submitted after the deadline may be delayed or denied review.

CHECKLIST FOR SUBMITTAL

The unbound Application must be submitted in the following order:

Please note: A cover letter is not necessary.

☐ Summary Sheet, completed.

☐ Applications that fail to adequately answer ALL the questions will NOT be considered for review. The Application should be NO MORE than two (2) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. Each narrative question must be answered in the order presented. Each page should be numbered and have the name of your Project and the Agency re-applying for funding.

☐ Services to be Provided list, completed.

☐ Schedule of Fees to be Charged. Please include a copy of your schedule of client fees. If the applicant does not require their clients to pay a co-payment, please explain why.

☐ Self-Evaluation Report for the period October 1, 2003 to April 30, 2004 using the forms provided.

☐ Annual Report. Please include a copy of your Agency's most recent Audited Annual Report.

☐ Checklist. Please include this completed Checklist with your Application.

Only Private Non-Profit Agencies and Public Entities are eligible for funding
(Section 26-17-302(1), UCA).

ONLY AGENCIES AWARDED IN STATE FISCAL YEAR 2003-2004
WILL BE CONSIDERED FOR THIS APPLICATION.

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2004-2005 Summary Sheet

IDENTIFYING INFORMATION	
Title of Project:	
Name of Agency:	
Contact Name & Title:	
Mailing Address:	
City, State, Zip:	
Telephone: ( ) -	Fax: ( ) -
Email Address:	
Tax Identification Number: 00-0000000	

PROJECT SUMMARY INFORMATION (October 1, 2004 through June 30, 2005)		
Dollar Amount for Project: $		
Project Expects to Serve (for the period October 1, 2004 through June 30, 2005)	Number of Users: The number of medically underserved individuals the Project plans to serve.	Number of Encounters: The aggregate numbers of encounters that are expected to be provided.
The Precise Boundaries of the Area to be Served [City(s) and/or County(s)]:		

PROPOSED BUDGET (October 1, 2004 through June 30, 2005)			
Line Item Category	**Requested Funding**	**Other Sources**	**Total**
Salary & Fringe Benefits	$	$	$
Travel	$	$	$
Equipment	$	$	$
Supplies	$	$	$
Contractual	$	$	$
Total Costs	$	$	$
Total Program Income	$	$	$

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2004-2005 Application

The Application should be NO MORE than two (2) pages total with one inch margins. The font should NOT be smaller than 10-point. Lines should be double-spaced. Each narrative question must be answered in the order presented. Each page should be numbered and have the name of the Project and the name of the Agency re-applying for funding. Please be concise and succinct. Note that the budget narrative (described below) is separate from the Application. Applications that are submitted after the deadline may be delayed or denied review.

Each question must be answered in the following order:

1. **TARGET POPULATION(S)**: Briefly describe the medically underserved population(s) that the grant objectives will serve and include an assessment of need for this population.

2. **OBJECTIVES/EVALUATION**: Provide specific, measurable objective(s) as well as proposed activities, outcomes, and measures for each objective.

3. **COLLABORATION**: Provide information about any existing or future partnerships, collaborative efforts, use of volunteers, or other resources that your Agency will use to complete the objective(s).

4. **SUSTAINABILITY OF FUNDING**: Provide a plan of financing for the target population(s), *if State Primary Care Grants Program funding were no longer available*. Also provide evidence of "Other Sources of Funding" for the primary care services provided by your Project (e.g., funding from the Utah Department of Health, Cardiovascular Program, for blood pressure screening).

5. **BUDGET NARRATIVE**: Please provide a brief budget narrative. The budget narrative must explain each Line Item Category of the proposed budget (see the Summary Sheet). Briefly describe the personnel who will oversee and/or complete Project activities. Explain other sources of funding included in the budget, such as grants, third party payments (e.g., Medicaid, Medicare, CHIP, private insurance), donations, etc. Indicate if you will require less funding in State Fiscal Year (SFY) 2004-2005, than in SFY 2003-2004 (e.g., you expect to have fewer users/encounters).

   NOTE: Budgets should be for the period October 1, 2004 through June 30, 2005.

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2004-2005 Services to be Provided

Name of Grantee _____

Name of individual responsible for completing this report _____

Telephone number ( ) - _____

Services To Be Provided		
In Column A, please check all corresponding services that the Project expects to provide to eligible individuals.		
SERVICE TYPE		**COLUMN A**
Primary Medical Care Services	General Primary Medical Care	
	Diagnostic Laboratory	
	Diagnostic X-ray	
	Diagnostic Tests/Screens/Analysis	
	Family Planning	
	Following Hospitalized Patients	
	HIV Testing	
	Immunizations	
	Mammography	
	Tuberculosis Therapy	
	Urgent Medical Care	
	24 Hour Coverage	
OB/GYN Care	Gynecologic Care	
	Pap Smear	
	Obstetric Care	
	Prenatal Care	
	Labor and Delivery Professional Care	
	Postpartum Care	
Dental Services	Preventive	
	Restorative	
	Emergency	

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2004-2005 Services to be Provided

Name of Grantee _____

Name of individual responsible for completing this report _____

Telephone number ( ) -

Services To Be Provided		
In Column A, please check all corresponding services that the Project expects to provide to eligible individuals.		
SERVICE TYPE		**COLUMN A**
Mental Health Services	Mental Health Treatment/Counseling	
	Developmental Screening	
	24 Hour Crisis Intervention/Counseling	
	Other Mental Health Services	
	Substance Abuse Treatment/Counseling	
	Other Substance Abuse Services	
Other Professional Services	Hearing Screening	
	Nutrition Services Other than WIC (Women, Infants, and Children Supplemental Nutrition Program)	
	Occupational/Vocational Therapy	
	Physical Therapy	
	Pharmacy Services	
	Vision Screening	
Enabling Services	Case Management	
	Child Care (during visit to clinic)	
	Discharge Planning	
	Health Education	
	Home Visiting	
	Interpretation/Translation Services	
	Nursing Home & Assisted-Living Placement	
	Outreach	
	Parenting Education	
	Transportation	

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2003-2004 Self-Evaluation Report
Self-Evaluation Period: October 1, 2003 through April 30, 2004

Name of Grantee _____

Name of individual responsible for completing this report _____

Telephone number ( ) - _____

1. Encounter [1] information, October 1, 2003 through April 30, 2004

Baseline Data for Your Agency		**Primary Care Grant Encounters**	
Total number of encounters [1] for your Agency's most recent fiscal year	Projected total number of encounters [1] for the period 10/1/03 - 6/30/04	Total number of primary care grant patient encounters [1] 10/1/03 - 4/30/04	Number of ***new*** primary care grant patient encounters [1] 10/1/03 - 4/30/04
	000		

For the Following Tables Please Use Actual Figures, or Best Estimates of Users Funded by the Grant.

2. Users [2] by Age, October 1, 2003 through April 30, 2004

Age Groups	**Number of Users [2]**
0 - 19	
20 - 64	
65 and over	
Total Users [2]	

3. Users [2] by Income Level, October 1, 2003 through April 30, 2004

Percent of Poverty Level	**Number of Users [2]**
100% and below	
101 - 200%	
Above 200%	
Unreported/unknown	
Total Users [2]	

1 "Encounter" means a face-to-face contact between an eligible individual and the GRANTEE's provider who exercises independent judgement in the provision of services to the eligible individual and where the services provided under the State Primary Care Grants Program are rendered and recorded in the eligible individual's record.

2 Users are defined as "Eligible Individuals", who received at least one face-to-face encounter October 1, 2003 through April 30, 2004.

STATE PRIMARY CARE GRANTS PROGRAM
FOR MEDICALLY UNDERSERVED POPULATIONS

State Fiscal Year 2003-2004 Self-Evaluation Report

Self-Evaluation Period: October 1, 2003 through April 30, 2004

Name of Grantee _____

Name of individual responsible for completing this report _____

Telephone number ( ) - _____

4. Total Users [2] by Insurance Status, October 1, 2003 through April 30, 2004

Number Users [2] Uninsured	Number Users [2] Underinsured

5. Users [2] by Race/Ethnicity, October 1, 2003 through April 30, 2004

Race/Ethnicity	Number of Users [2]
Asian	
American Indian or Alaska Native	
Black or African American	
Native Hawaiian or Other Pacific Islander	
White	
Hispanic or Latino	
Other	
Unreported or Unknown	
Total Users [2]	

6. Please summarize the self-declared goals and objectives including quality of care for the period October 1, 2003 through April 30, 2004.

7. Describe how your Agency has met the objectives of your Application, and if the objectives have not been met, please explain.

8. Please provide evidence of the sustainability of your Agency.

9. *Optional*: If there is other information that you would like to provide about your Grant objectives and implementation of those objectives, or the need for your Program, please describe below (no more than one paragraph).

1 "Encounter" means a face-to-face contact between an eligible individual and the GRANTEE's provider who exercises independent judgement in the provision of services to the eligible individual and where the services provided under the State Primary Care Grants Program are rendered and recorded in the eligible individual's record.

2 Users are defined as "Eligible Individuals", who received at least one face-to-face encounter October 1, 2003 through April 30, 2004.